February 21, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0610-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The patient developed low back and leg pain following a work injury on ___. She underwent an unsuccessful lumbar fusion in 1999 and had removal of the hardware in 2000. Her pain remained the same. Analgesic medication has been prescribed for her. She was seen by ___ in October 2002 for a consultation, and after adjusting her medication he prescribed an Orthotrac Pneumatic Vest (OPV) in November. It was provided to the patient by the vendor. According to follow-up reports on 12/26/02 and 1/20/03 she was wearing it. It was stated that the OPV had proven to be of "dramatic benefit" and that the patient reported "excellent relief of her symptoms." The patient was also noted to have reported that she was not anticipating returning to her job. The prescriptions for NSAID and narcotic analgesic medication appeared to be unchanged from before use of the OPV.

REQUESTED SERVICE

The purchase of an Orthotrac Pneumatic Vest is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The literature provided to support the clinical use of the OPV is decidedly lacking in the design of prospective controlled studies to clearly demonstrate the effectiveness of a new treatment. The one case study presented in the company's promotional report does not provide convincing evidence for the proposed physiologic rationale for the device. The latest edition of clinical evidence (BMJ Publishing Group, December, 2002) reports that the evidence from peer-reviewed studies so far indicates that lumbar supports and traction are of unknown effectiveness and likely to be ineffective, respectively in the treatment of chronic low back pain.

Though the clinical notes about this patient contain remarkable claims concerning the benefits she has gained from the OPV, it does not appear that she is likely to return to gainful employment and she is still requiring daily narcotic analgesic medication for her symptoms. Long-term benefits from the OPV are unproven. The purchase of an Orthotrac Pneumatic Vest for this patient does not appear to be medically necessary.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 21st day of February 2003.